

Massachusetts Division of Health Care Finance and Policy

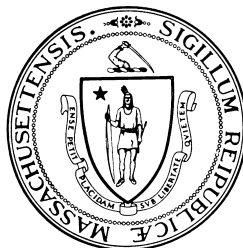
An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents

Chapter 3: The Uncompensated Care Pool

A Report to the Senate Committee on Ways and Means,
House Committee on Ways and Means
and Joint Committee on Health Care

November 2000

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**An Evaluation of Programs for Low Income Uninsured and Underinsured Massachusetts Residents
Chapter 3: The Uncompensated Care Pool**

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Executive Summary

This report on the Uncompensated Care Pool is part of the Division of Health Care Finance and Policy's assessment of the health reforms initiated by Chapter 47 of the Acts of 1997. The Acts brought about many changes to the financing and management of the Uncompensated Care Pool. Chapter 47 added \$85 million annually for uncompensated care: \$70 million to Boston Medical Center and Cambridge Health Alliance through an intergovernmental transfer, and \$15 million to the Uncompensated Care Pool from the Commonwealth's General Fund. It also replaced \$100 million funded through an assessment on hospitals with a direct surcharge on payers. In addition to implementing the changes in financing of the Pool, the Division improved the functioning of the Uncompensated Care Pool by standardizing the process for determining eligibility, creating a uniform application, and assisting providers with these changes. The additional funds, the expansion of MassHealth, and the new management initiatives together have allowed more providers to become net receivers from the Pool and have allowed the funds to be better targeted to low-income uninsured and underinsured individuals. The Uncompensated Care Pool had a surplus in Pool Fiscal Years 1998 (PFY98) and 1999 (PFY99), ending a series of annual shortfalls that began in 1989.

In addition to the changes already implemented, the Division is currently implementing an electronic application and completing development of a claims data collection system for services provided. These systems will offer precise and comprehensive information about individuals who access health care services through the Pool. The Division is also funding and evaluating demonstration projects to test innovative care models for individuals who rely on free care. These efforts follow the Division's goal of maximizing the efficiency of the Uncompensated Care Pool by reducing costs and improving care.

Key stakeholders were interviewed to gather some of the data used in this analysis; they acknowledge how health reform has improved Pool operations and are pleased to have a fully funded Uncompensated Care Pool. At the same time, however, stakeholders are concerned about how the state will sustain funding for uncompensated care once the MassHealth waiver, which authorized the intergovernmental transfer, expires in June of 2002. They are also concerned about the burdens that some of the management initiatives will place on them.

Recommendations for next steps focus on how to build upon the gains made over the last two years. The analysis presented here suggests that future effort should focus on three main issues:

- Continued investment in data and the ability to link these data among state agencies;
- Continued efforts to improve overall management of the Pool; and
- Sustaining the financing to support the continuation of health reform.

Section 1: Introduction

Authorization for Evaluating Health Reform: 1997 Session Laws, Chapter 47

This report on the Uncompensated Care Pool (the Pool) is part of the Division of Health Care Finance and Policy's (DHCFP; the Division) second assessment of the health reform initiatives mandated by Section 17 of Chapter 47 of the Acts of 1997, *An Act Assisting in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth*. This statute requires the Division of Health Care Finance and Policy to arrange for assessments of the MassHealth program, the Senior Pharmacy Assistance Program, the Children's Medical Security Plan and the Uncompensated Care Pool. This year's assessment comprises four separate reports, one for each of the programs mentioned, and succeeds the Division's March 1998 report, "An Evaluation of the Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents."

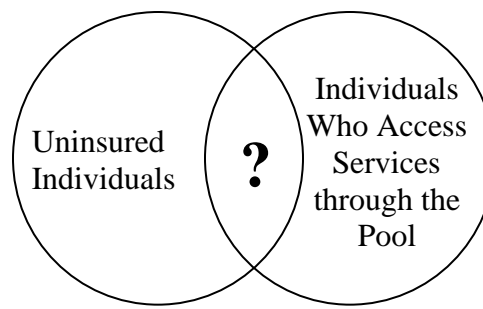
The Uncompensated Care Pool is the payer of last resort (safety net) for low-income people who are without health insurance or who have insurance but have no means to pay their deductibles or other obligations after insurance (the underinsured). Non-reimbursed care given by physician practices and other organizations not eligible to receive reimbursement from the Pool is not discussed in this report and is not accounted for by the Division.

Many Factors Affect the Number of Uninsured and Uncompensated Care

At the beginning of the 1997 health reforms, stakeholders anticipated that the MassHealth expansion would reduce the number of uninsured in the state, which would in turn reduce demand on the Uncompensated Care Pool. There is not, however, a perfect correlation between expanding MassHealth eligibility and reducing demand for uncompensated care. Expanding eligibility for MassHealth is only one step towards increasing enrollment and is only one of many factors affecting the number of uninsured. The economy and the availability of affordable insurance, for instance, can greatly affect the number of uninsured. In addition, changes to the welfare system may also affect the number of uninsured, depending on whether people leaving welfare obtain privately-purchased coverage through work or whether they continue participating in MassHealth. The extent and efficacy of outreach efforts for MassHealth perhaps have a greater impact on the number of uninsured than expanding the eligibility criteria. Furthermore, the recent re-determination process for MassHealth eligibility is likely to increase the number of uninsured, as participants fail to renew their enrollments or are no longer eligible. The amount of funding needed for the Uncompensated Care Pool depends not only on the MassHealth program, but also on hospital costs, the extent to which uninsured and underinsured individuals seek services, and the procedures in place for determining eligibility and making reimbursements.

As discussed in a separate report in this series, MassHealth is the Commonwealth's largest and most comprehensive public health program. There are many other programs available as well.¹ The uninsured are those individuals who are not eligible for one of these programs, those who are eligible but are not enrolled, and those who do not buy or earn privately-purchased health insurance. The uninsured population and the population of people who access health care through the Pool are not the same, however: only a portion of the uninsured actually access health care services through the Pool, and only a portion of individuals who access services through the Pool are uninsured. The two groups are related, to be sure, and the number of uninsured individuals certainly affects demand on the Pool; but, as shown in Figure 1, the extent to which these two groups overlap is not yet known.

Figure 1: Relationship of Uninsured Individuals to Individuals Who Access Services Through the Uncompensated Care Pool



This Report

This report provides results of analyses of available empirical data and also includes the results of interviews conducted by an independent consultant. Interviews were conducted with individuals representing various institutions and interests who have first-hand knowledge of the Pool and its impact on providers or patients. This report relies extensively on their input. The report is organized into five sections:

- Section 2 of this report describes the uninsured in Massachusetts, using data from DHCFP's 1998 and 2000 health insurance surveys and from the state's Uniform Hospital Discharge Data Set (UHDDS).²

¹ For a compendium of available state and federal programs, see Wolfsfeld, Lynn. *Access to Health Care in Massachusetts: A Catalogue of Health Care Programs for Uninsured and Underinsured Individuals*. Division of Health Care Finance and Policy, May, 2000.

² In 1997, as part of its work for the Special Commission on Uncompensated Care, the Division collected data on the individuals who accessed health care services through the Pool and described their characteristics. The data were from 1993-95 and are the most recent of this type. Beginning in 2000, the Division will collect information about the individuals who apply for free care and about the Pool-paid services they access. Subsequent assessments will make use of these data.

- Section 3 provides an overview of the Uncompensated Care Pool and describes the recent changes that occurred as part of Chapter 47. Much of this section appeared previously in *Free Care Reform* (1999), *The Free Care Application: A Guide for Acute Hospitals and Community Health Centers* (1999), or *Uncompensated Care Pool PFY99 Annual Report* (2000), all published by the Division of Health Care Finance and Policy.
- Section 4 is based on the interviews with key stakeholders and discusses various issues that have arisen during the implementation of the changes.
- Section 5 reviews the current status of the Uncompensated Care Pool, using data from Pool reimbursements and identifies challenges and options for moving forward.
- A list of interviewees appears in Appendix I.

Section 2: Overview of the Uninsured in Massachusetts

To complete this report, we analyzed two types of databases that contain information on individuals who are uninsured and their health care utilization: the Division's Surveys of Health Insurance and the Commonwealth's Uniform Hospital Discharge Data Set (UHDDS). Data for both these sources were gathered in 1998. By the time this report was finished, the Division had also completed its 2000 Survey of Health Insurance. However, comparable discharge data were not yet available. Therefore, most of the analyses presented here draw from the 1998 data so that information about the individuals who are uninsured and their health care utilization can be examined simultaneously. At the time of this writing, only limited information was available from the 2000 survey and thus most of the information we present is derived from the 1998 survey.

Who Are the Uninsured?

Uninsured people are not covered by public or private insurance. The Division's 1998 health insurance survey estimated that 8.2 percent (498,837 persons) of Massachusetts residents were uninsured. By 2000, an estimated 5.9 percent (364,622 persons) of Massachusetts residents were uninsured.³ The reasons individuals are uninsured are many, but affordability is a primary factor: 87 percent of uninsured individuals in Massachusetts in 1998 reported cost as being a factor in their not obtaining needed health care. This is not surprising, because most of the uninsured are low-income workers. Only 16 percent of uninsured individuals had family incomes above 400 percent of the federal poverty income guideline in 1998.⁴

Among non-senior adults in Massachusetts (ages 19-64), uninsured individuals are younger when compared to the insured population: the median age for uninsured individuals is 35 years, whereas the median age for insured individuals is 40 years. Even though they are younger than insured individuals, people who are uninsured rated their health "fair" or "poor" about as often as insured individuals. When compared to insured individuals of the same ages, uninsured individuals over 44 years were much more likely to report their health as "fair" or "poor" (see Figure 2).⁵ Two thirds of the working uninsured population in Massachusetts reported that they were in "excellent" or "very good" health in 1998.⁶

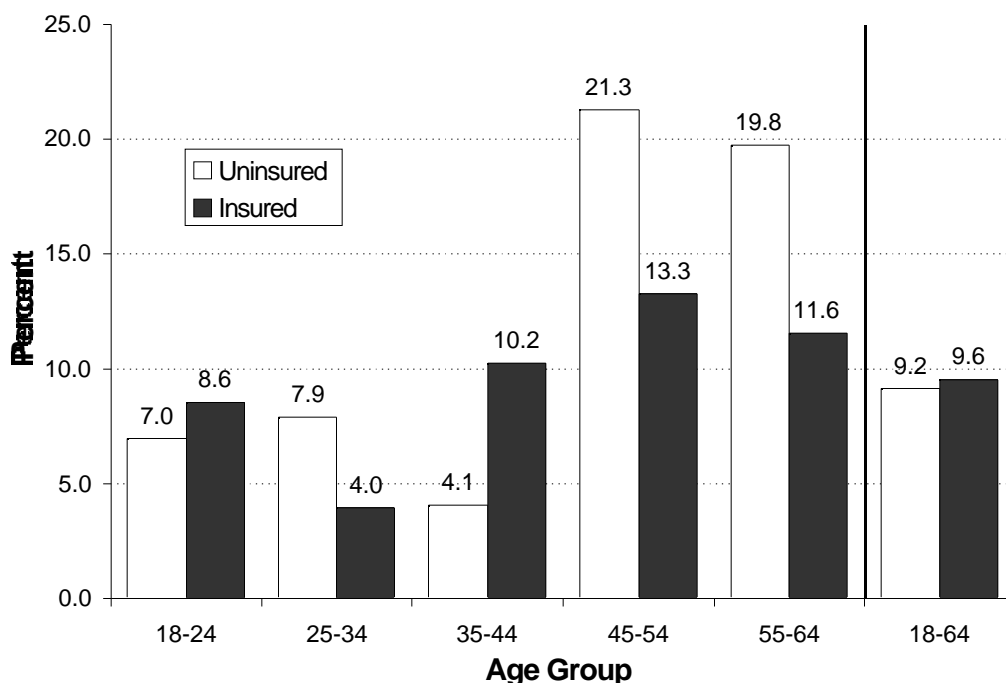
³ Analysis of the 1998 and 2000 Surveys of Health Insurance, Division of Health Care Finance and Policy. The 1998 estimate is from the mixed-mode survey; the 1998 telephone survey estimated the uninsured to be 7.7 percent, or 473,209 residents.

⁴ Analysis of the 1998 Survey of Health Insurance, Division of Health Care Finance and Policy.

⁵ Analysis of the 1998 Survey of Health Insurance, Division of Health Care Finance and Policy.

⁶ Sharma, Shyamal. "Working Uninsured: A Priority for Health Insurance Reform." *Healthpoint*. No. 12, January 1999, p. 2; from the analysis of the 1998 Survey of Health Insurance, Division of Health Care Finance and Policy.

Figure 2: Percent Massachusetts Residents Ages 18-64 Reporting Their Health Status as "Fair" or "Poor" by Age and Insurance Status, 1998



Source: 1998 Survey of Health Insurance, Division of Health Care Finance and Policy.

The Use of Outpatient Services by Uninsured Individuals

According to DHCFF's 1998 survey, uninsured non-elderly adults were more likely to receive care in hospital emergency rooms and less likely to receive care in office settings than insured adults (See Table 1). Available data do not allow us to determine the proportion of these outpatient costs reimbursed by the Pool.

Table 1: Percent Office Visits and Emergency Room Visits by Insurance Status for Non-Elderly Adults, 1998

Number of Visits	Office Visits		Emergency Room Visits	
	Insured	Uninsured	Insured	Uninsured
None	16.2	53.6	70.0	52.0
1 or more	83.8	46.4	30.0	48.1
1 to 4	53.5	33.1	26.7	43.1
5 or more	30.3	13.2	3.3	5.0
Total	100.0	100.0	100.0	100.1

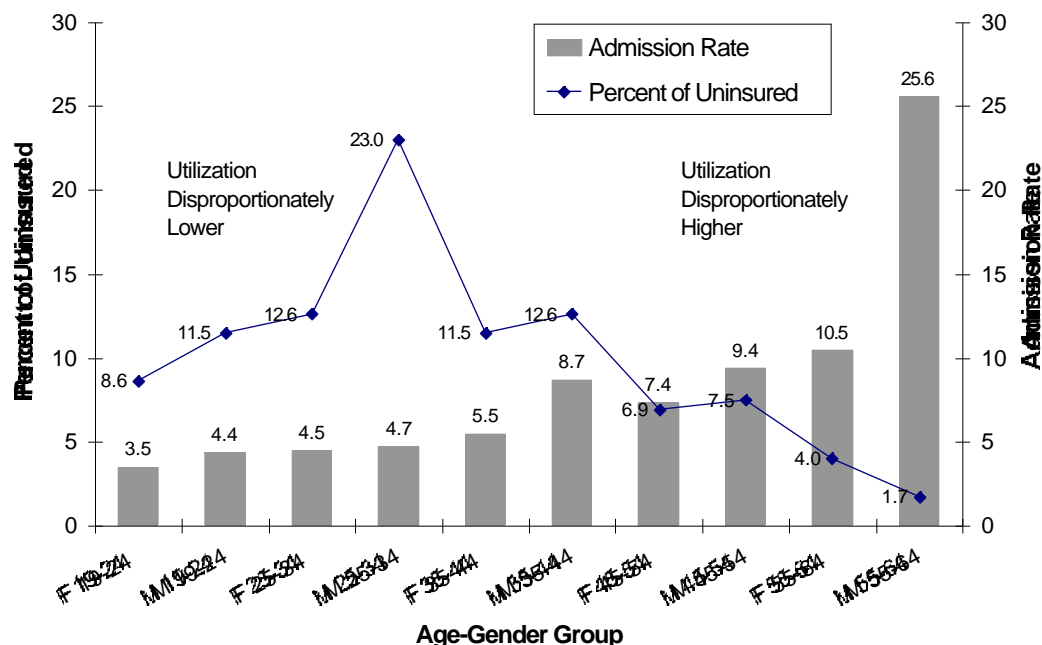
Source: 1998 Survey of Health Insurance, Division of Health Care Finance and Policy.

The Use of Inpatient Services by Uninsured Individuals

The Division is the central repository for the Commonwealth's Uniform Hospital Discharge Data Set (UHDDS), which provides detailed information on use of inpatient services. We believe that these data are a good reflection of the inpatient services received by uninsured individuals. The UHDDS, however, is not necessarily representative of the services paid for by the Pool or the people who apply for free care because it does not identify patients for whom the Pool paid for care and is not associated with the process for distributing Pool funds. Nonetheless, since the UHDDS provides comprehensive information about all hospital discharges, we used this database to examine the discharges of uninsured inpatient residents (those with payer types "Free Care" or "Self Pay"). We compared the findings of this analysis to the results of the DHCFP survey. We describe our methodology and the limitations of using the UHDDS in Appendix II.

In Pool Fiscal Year 1998 (PFY98), 22,605 uninsured residents 19-64 years old were admitted to the hospital (excluding birth-related admissions). This is less than 6 percent of the estimated 387,489 uninsured individuals in that age group, indicating that most (94 percent) of the uninsured persons in that age group were not hospitalized. The uninsured residents who access inpatient services are a specific subset of the uninsured: those who are older and sicker, and those who are younger who have substance abuse and psychiatric problems.

Figure 3: Distribution of the Uninsured Population and Estimated Hospital Admission Rates of Uninsured Individuals by Age-Gender Group, Ages 19-64, PFY98



Sources: *Percent Uninsured* is estimated by the 1998 Survey of Health Insurance, Division of Health Care Finance and Policy.

Admission Rates are calculated by dividing the number of admissions from the States' Uniform Hospital Discharge Data Set by the estimated number of uninsured from the 1998 Survey of Health Insurance, for each age-gender group.

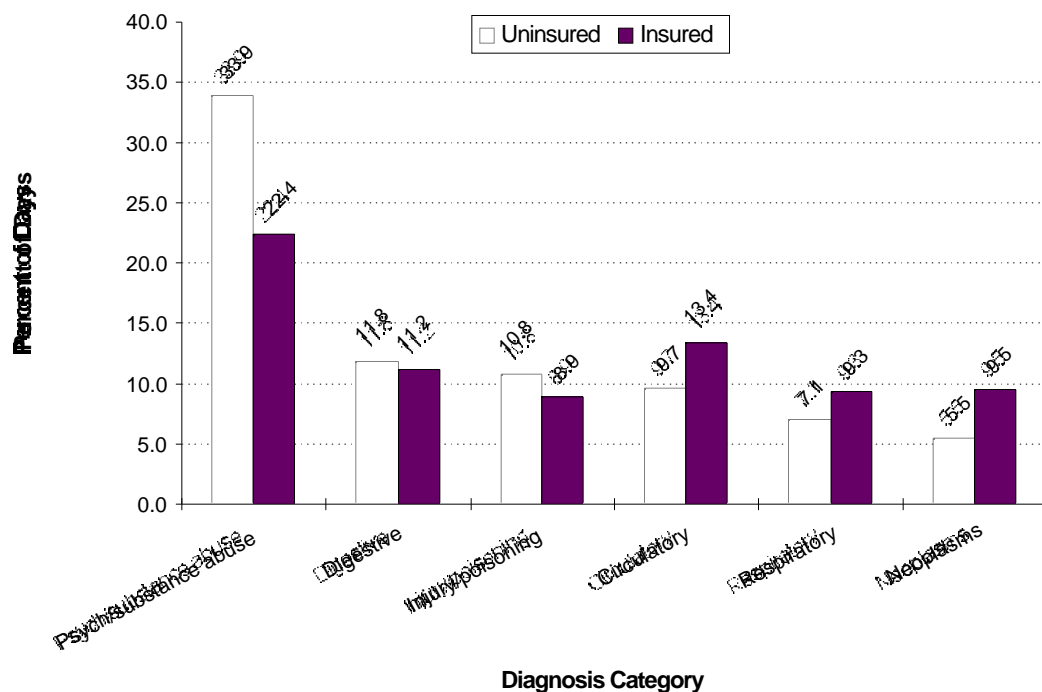
Demographics

Only 5.7 percent of the state's adult, non-senior uninsured are over 54; however, they have an estimated annual hospitalization rate of 15 percent (26 percent for the men and 11 percent for the women). On the other hand, younger uninsured individuals (under age 35) compose 55 percent of the uninsured, but have an estimated hospitalization rate of just 4.4 percent (see Figure 3).

Clinical Profile

Uninsured inpatients diagnosed with substance abuse or psychiatric conditions accounted for 34 percent of inpatient days (see Figure 4).⁷ *Digestive disorders* accounted for almost 12 percent of inpatient days among individuals without insurance, while *Injuries and poisonings* was the third most common diagnostic category for this population (10.8 percent).

Figure 4: Inpatient Days for the Top Six Diagnostic Categories for Uninsured and Insured Inpatients, Ages 19-64



Note: See Appendix II for a detailed description of our use of discharge data; data utilized were taken from 1997, 1998, and 6 months of 1999. The top diagnoses in this analysis differ from the top three diagnoses listed in the Division's 1997 *Report of the Special Commission on Uncompensated Care* because the previous analysis examined all ages, whereas this analysis included ages 19-64 only.

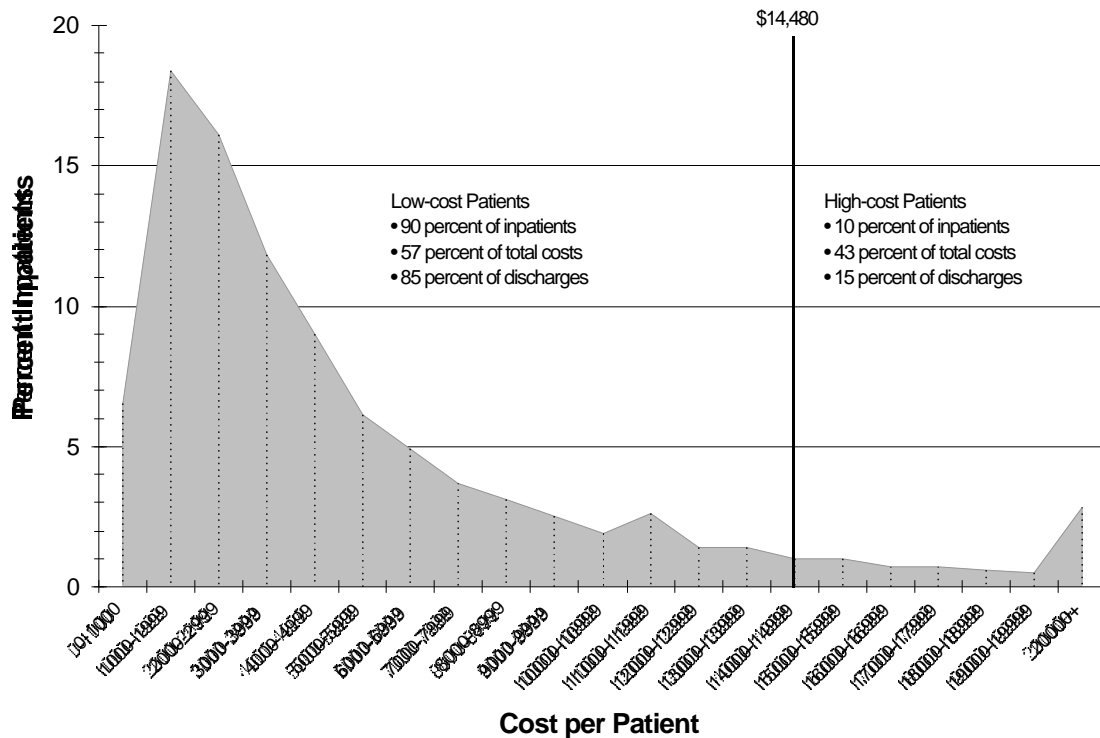
Source: Analysis of the Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy.

⁷The top three DRGs for uninsured inpatients are *psychoses* (430), *opioid abuse or dependence without complications* (745), and *alcohol abuse or dependence without complications* (751), all of which are categorized as *Psychological/Substance abuse*.

Cost

A small percent of adult, non-senior, uninsured inpatients account for a disproportionate share of the overall inpatient costs incurred by this group. We estimated that 43 percent of the inpatient costs were spent on just 10 percent of the uninsured inpatients, and that each of these high-cost inpatients incurs a cost of \$14,480 or more. Ninety percent of uninsured inpatients in that age group incur costs under \$14,480 (see Figure 5). The high-cost individuals appear to have very expensive episodes of hospitalizations. As a group they account for just 15 percent of the discharges among uninsured inpatients ages 19-64.

Figure 5: Distribution of Cost per Uninsured Inpatient, Ages 19-64



Source: Analysis of the Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy.

Trends in the Uninsured, Pool Fiscal Years 1997-1999

There appears to have been a slight decrease in the number of uninsured and in the number of inpatient discharges among the uninsured in recent years. These decreases may be related to (among other things) the strength of the economy in Massachusetts and to the expansion of the MassHealth program, both of which increase the accessibility of health insurance coverage.

In 1998 and 2000, the Division conducted surveys designed to produce state-level estimates of the number of Massachusetts residents who are uninsured. In 1997 and 1999, the Urban Institute conducted their National Surveys of America's Families, which also were designed to yield Massachusetts-specific estimates. The uninsured rate appears to have declined during the period

of health reform, from about 8.2 percent to 5.9 percent over all ages, and from 9.3 to 6.5 percent for non-elderly individuals (See Table 2).

Table 2: Recent Estimates of the Uninsured in Massachusetts, Ages 0-64

	1997	1998	1999	2000
Surveys Designed for Massachusetts Estimates				
DHCFP Surveys of Health Insurance	-	9.3	-	6.5
Urban Institute National Survey of America's Families	9.9	-	6.9	-

Note: The two surveys designed for state-level estimates use different methodologies and should not be combined to examine trends in insurance coverage.

Sources: Division of Health Care Finance and Policy, Surveys of Health Insurance.

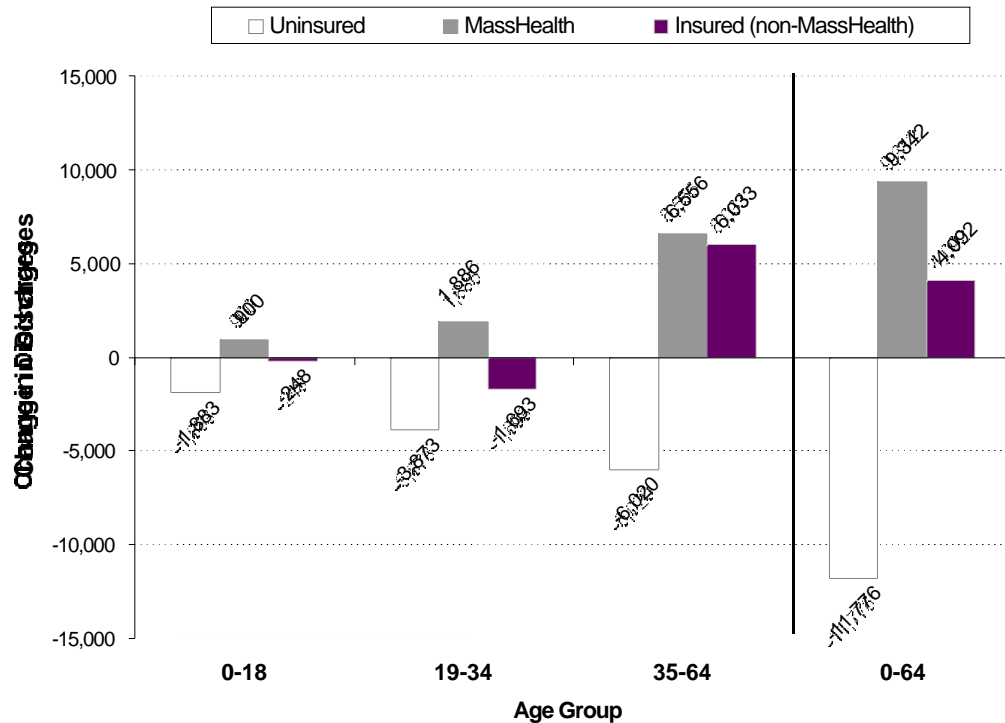
Urban Institute, 1997 and 1999 National Surveys of America's Families (NSAF) and *Health Insurance Access, and Use: Massachusetts*, State Profiles, July, 2000.

In addition to presenting results of the surveys, we examined the Division's hospital discharge data for evidence about the impact of the MassHealth expansion on the uninsured. Pool Fiscal Year 1997 (PFY97) ended in September of 1997, before the changes initiated by Chapter 47 were implemented. Using PFY97 as a base year, we analyzed the changes in total discharges, birth-related discharges and discharges among children. We focused on discharges for individuals ages 0-64, who were either uninsured or covered by MassHealth.

Total Discharges

Between PFY97 and PFY99, non-birth related admissions of uninsured residents under 65 years of age decreased by 11,776 (33 percent); in contrast, admissions for MassHealth participants increased by 9,342 (23 percent). These changes are large when compared to changes in the number of admissions for residents in the same age group who were insured (through means other than MassHealth), which increased by just 4,092 (2 percent). The changes among the uninsured and MassHealth groups are significant and appear to reflect greater participation in MassHealth by previously uninsured individuals (See Figure 6). To further understand these trends, the Division's new data systems, discussed in Sections 3 and 4, could be used in combination with data from MassHealth to more accurately understand movement of individuals between being uninsured and being covered through MassHealth.

Figure 6: Change in Total Number of Nonbirth-Related Inpatient Discharges by Age Group and Insurance Status, Pool Fiscal Years 1997-99



Source: Analysis of the Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy.

Discharges Among Children

Children up to 200 percent of the federal poverty income guideline (FPIG) are eligible for MassHealth. Other children in low-income families presently have health insurance available to them through the Children's Medical Security Plan (CMSP). CMSP does not cover hospitalizations and the premium is fully paid by eligible families who have incomes greater than 400 percent FPIG. Discharges for uninsured children (ages 0-18) declined by 1883 between PFY97 and PFY99 (60 percent) and increased by 900 (8 percent) for MassHealth recipients (see Figure 6). Although the number of inpatient discharges for children decreased, some children still appear not to have coverage for hospitalizations. It is likely that some of these individuals are enrolled in the CMSP, which does not cover hospitalizations. Others may be in the process of applying for MassHealth, are undocumented immigrants, or have parents who do not wish to enroll them in MassHealth. The reforms seem to have been successful in reaching children, but some children may continue to face barriers to health care coverage.

Birth-related Discharges

We also examined the birth-related discharges over the past three years. MassHealth should cover most pregnant low-income women (see Table 3). Between PFY97 and PFY99, the number of birth-related hospitalizations of uninsured individuals declined by 2561 (47 percent) while the number of birth-related discharges for MassHealth recipients increased by 2079 (4 percent). This may reflect a movement of some individuals from being uninsured to being covered by MassHealth. In PFY99, however, many women appear to have gone without coverage for their births, as there were 3688 birth-related discharges among the uninsured. These individuals may have been part of the Healthy Start program, which covers prenatal care and some postpartum services, but does not cover labor and delivery (Healthy Start enrollees are eligible for MassHealth Limited, which pays for hospitalizations). Some of these individuals may have been eligible for MassHealth but did not complete an application, or had an application pending approval.

Table 3: Birth-Related Discharges Among MassHealth and Uninsured Inpatients, Pool Fiscal Years 1997-1999

	PFY97	PFY98	PFY99	1997-1999 Change	1997-1999 % Change
Uninsured	6,249	5,440	3,688	(2,561)	(47.2)
MassHealth	33,423	32,307	35,502	2,079	3.9

Source: Analysis of the Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy.

Section 3: The Uncompensated Care Pool and Key Changes Since 1997

Overview of Uncompensated Care

Massachusetts is one of a handful of states (like Connecticut, Maryland, New Jersey, and New York) that uses an uncompensated care pool to reimburse hospitals for uncompensated care. The Commonwealth's Pool is an important component of the state's health care safety net. Unlike public insurance programs or commercial insurance products, however, it has no benefit package, and no cost sharing; unlike coordinated care products or systems, the administrator (DHCFP) does not conduct utilization review or have a quality assurance process. The Pool pays for part or all of the medically necessary services provided by acute care hospitals and community health centers to low-income uninsured or underinsured individuals when no other source of payment exists.⁸

Several aspects of Pool operation have changed as a result of the legislative mandates enacted in 1997. The Uncompensated Care Pool historically has been a reimbursement mechanism for eligible providers. Over time, the focus of the Pool shifted from providers to patients, a shift that was formally recognized in Chapter 47 of the Acts of 1997:

The purpose of [the Uncompensated Care Trust Fund] shall be to provide access to health care for low-income uninsured and underinsured residents of the Commonwealth.

MGL c.118G, §18.

*Types of Free Care*⁹

Once a patient submits a completed application with documentation and qualifies for free care, eligible providers can be reimbursed from the Uncompensated Care Pool for medically necessary services provided to that patient. There are three types of free care: full free care, partial free care, and medical hardship assistance. *Full free care* is available for people with family incomes up to 200 percent of the federal poverty income guideline (FPIG). Payments for services provided to individuals in this category account for the largest share of Pool spending. *Partial free care* is available for people with family incomes of 201-400 percent FPIG. Payments made on behalf of eligible patients in this category are the same as with full free care, but are made only after patients reach an annual income-based deductible. At community health centers, recipients of partial free care pay for services according to a sliding fee scale until they reach their deductibles. *Medical hardship* assistance is available for people of any income whose allowable medical expenses exceed their ability to pay them. An asset test is required for patients applying for medical hardship.

⁸ Commonwealth of Massachusetts. *Criteria For Determining Eligibility For Free Care At Acute Care Hospitals and Freestanding Community Health Centers*, 114.6 CMR 10.02. Boston: Division of Health Care Finance and Policy, 1998.

⁹ A thorough discussion of the types of free care and the eligibility guidelines appears in *The Free Care Application: A Guide for Acute Hospitals and Community Health Centers*. Division of Health Care Finance and Policy, November, 1999.

Emergency Bad Debt

In addition to full free care, partial free care and medical hardship assistance, the Pool also pays for bad debt resulting from emergency services provided to uninsured patients. Federal law requires hospitals to provide a medical screening examination by qualified personnel to anyone who presents for an unscheduled treatment; then, if the clinician determines there is an emergency, they are required to treat the patient.¹⁰ Therefore, when anyone visits one of the state's hospitals with a medical emergency, the hospital must provide treatment, regardless of the patient's insurance status. In Massachusetts, providers and insurers use the "prudent layperson" standard for determining whether a visit constitutes an emergency. If the patient is uninsured, and if the provider cannot collect payment within 120 days, and if a free care application is not completed by the patient to verify eligibility for free care, then the Pool reimburses these costs as *emergency bad debt*. Emergency bad debt constitutes approximately 20 percent of free care reimbursements from the Uncompensated Care Pool. The Pool pays for emergency bad debt as a last resort to ensure that hospitals help patients complete a free care application, bill them, or enroll them into available programs such as MassHealth, where appropriate.

Eligibility for Free Care

In October of 1998, DHCFP standardized the eligibility rules for free care and created a uniform application available in numerous languages.¹¹ To facilitate compliance, staff in the Division's Pricing Group wrote and distributed a written guide to providers, ran training sessions throughout the state, and established a telephone line to answer questions from patients and providers. According to DHCFP staff, DHCFP currently receives about eight calls each day on this help line. The Division received many questions when it first implemented the new policies and procedures; now that providers have learned about the changes, the questions received are fewer and tend to be about complex issues or exceptions to Pool policies.

Screening Requirements

The changes implemented as part of Chapter 47 and the new regulations codified the Pool's role as a safety net existing among a range of available options and programs, most notably MassHealth. The Uncompensated Care Pool is the Commonwealth's payer of last resort, to be used when no other source of coverage exists. Hospitals and community health centers now must screen free care applicants for eligibility for MassHealth and other programs and assist them in applying for these benefits. The screening requirements help to ensure that the Pool funds are spent for their intended purpose and that patients are enrolled in the most comprehensive programs for which they qualify.

Massachusetts Residency

Massachusetts residents who complete a free care application and who qualify can receive both scheduled and non-scheduled medically necessary services. Medical necessity is defined in the regulations and generally can include emergent, urgent, and scheduled services. Non-residents are

¹⁰ 42 USC 1395(dd). a.k.a. EMTALA.

¹¹ The free care application is available in Chinese, English, Haitian Creole, Khmer, Portuguese, Spanish, and Vietnamese.

eligible for emergent and urgent services only. The Acts of 1997 instituted the residency requirement for non-emergency and non-urgent services, so non-residents can no longer access scheduled medically necessary services through the Commonwealth's Pool. A resident is defined as someone who lives in Massachusetts and who intends to stay indefinitely; it is not contingent upon citizenship or immigration status.

Appeals

As part of its effort to improve management of the Pool, DHCFP implemented a formal grievance and appeals policy. Before October of 1998, hospitals were under no obligation to reveal the appeals process to consumers. Now, when consumers apply for free care, they must be informed about the appeals process available through DHCFP. To appeal decisions about eligibility, consumers must submit a written complaint to DHCFP.

Access to Services

Private physicians, independent practices, and many clinics are not eligible to receive reimbursement from the Pool. The Division does not monitor or collect information about uncompensated care provided by these individuals or organizations. The Pool's regulations allow reimbursements to acute care hospitals and community health centers for services that they are licensed to provide.¹² This can cause some inequities in access to some services. For example, hospitals running their own outpatient pharmacies can be reimbursed for medications dispensed, whereas most community health centers cannot offer Pool-reimbursed prescriptions because they do not have outpatient pharmacies. Often providers without licensed pharmacies rely on indigent drug programs or free samples for their free care patients. This is another source of uncompensated care not reflected in the Pool's payments or a provider's uncompensated care submissions.

Data System

As part of its efforts to improve management of the Uncompensated Care Pool and as required by statute,¹³ DHCFP is developing a new data system for the Pool that includes two key components: an electronic application to verify patient eligibility for free care, and a claims reporting system to record medical services reimbursed by the Pool. Once fully implemented, these systems will provide DHCFP with new information to help improve operating efficiency and eligibility determinations. This will be the first system of its kind in the country.

Electronic Application

The Division has developed an electronic application to collect data on individuals who apply for free care, and it is currently being used by hospitals and community health centers. The electronic application can be used in conjunction with paper copies of the available translations for non-

¹² Commonwealth of Massachusetts. *Criteria For Determining Eligibility For Free Care At Acute Care Hospitals and Freestanding Community Health Centers*, 114.6 CMR 10.02. Boston: Division of Health Care Finance and Policy, 1998.

¹³ MGL c. 118G §18 as amended by Chapter 47 of the Acts of 1997.

English speaking applicants. The application is processed online within each provider facility and helps to verify whether an individual meets the eligibility criteria for free care. An actual determination of eligibility requires supporting documentation. The electronic program also contains information about other state health benefit programs and will help providers identify those programs for which a patient is likely to be eligible. It will not make a definitive determination of eligibility for other programs, however.

Claims Data

In addition to the electronic eligibility application, DHCFP is developing an electronic database for uncompensated care claims submissions. All Pool providers will record encounters for the database on the UB92, the standard claim form developed by the National Uniform Billing Committee. The claims data will assist the Division in managing the Pool by allowing staff to verify the accuracy of claims. The data will also provide comprehensive information about the services received by individuals who access care through the Pool.

Sources of Funding

The Uncompensated Care Pool is funded by three sources: a hospital assessment (\$215 million), a surcharge on payers (\$100 million), and the Commonwealth's General Fund (\$30 million).¹⁴ In addition, a complex intergovernmental transfer provides Boston Medical Center and Cambridge Health Alliance with a combined additional \$70 million for uncompensated care provided at those two hospitals. The hospital- and Uncompensated Care Pool fiscal years run from October 1 of the prior year through September 30 of the current year. Pool Fiscal Year 1998 (PFY98), for instance, includes three calendar months of 1997.

Surcharge

The 1997 reforms to the Pool instituted a surcharge on private payers, including HMOs, insurers and individuals. Private payers who make payments to a hospital or ambulatory surgical center are required to pay a surcharge on the payments. Individuals are required to pay the surcharge if they pay more than \$10,000 out of pocket to a hospital or ambulatory surgical center. Payments made on behalf of Medicare beneficiaries, Medicaid recipients, persons covered under other programs of government assistance, third party liability claims, and workers compensation are not subject to the surcharge. The total amount obtained by the surcharge is fixed by the legislation at \$100 million. The surcharge reduced by \$100 million the amount contributed by hospitals. Without the surcharge, the assessment on hospitals would be \$315 million, as it was before 1997.

Intergovernmental Transfer

Since state fiscal year 1998, the Commonwealth has been able to access an additional \$70 million in federal funds annually through an intergovernmental funds transfer (IGT). The Division of Medical Assistance pays these funds, which are appropriated each year in the state budget, to Boston Medical Center (\$51.8 million) and Cambridge Health Alliance (\$18.2 million) at the

¹⁴ Supplementary funding from other sources may be added under special circumstances. A complete discussion of the funding sources for the Uncompensated Care Pool can be found in the *Uncompensated Care Pool PFY99 Annual Report*, Division of Health Care Finance and Policy, March, 2000.

beginning of the state fiscal year. Free care provided by these two hospitals is funded first from the IGT and the Pool pays the remainder.

Payments from the Pool

More than half—58 percent in PFY99—of payments for uncompensated care are for outpatient services (see Table 4). Boston Medical Center and Cambridge Health Alliance—both teaching hospitals—are the largest providers of free care in the state, receiving 39 and 18 percent of free care reimbursements to hospitals in PFY99, respectively (see Table 5). Most of uncompensated care is provided at teaching hospitals, which tend to be larger and located in urban areas. Community hospitals, however, also provide a substantial amount of uncompensated care.

Table 4: PFY99 Payments from the Uncompensated Care Pool

Category	Percent
Total Hospital Outpatient	57.6
Emergency Bad Debt	13.3
Free Care	44.4
Total Hospital Inpatient	38.1
Emergency Bad Debt	6.3
Free Care	31.8
Community Health Centers	3.5
Demonstration Projects	0.8
Total	100.0

Source: Division of Health Care Finance and Policy Uncompensated Care Reimbursement Data.

Community Health Centers

Community health centers (CHCs) have received payments from the Pool since 1991. In PFY99, approximately 4 percent of Pool payments went to CHCs, although unlike hospitals, they do not contribute to the Pool. CHCs predominantly serve low-income individuals—those on MassHealth and those who qualify for free care—and the Pool is an important source of revenue for them.

Table 5: Percent of Hospital-provided Uncompensated Care by Hospital Teaching Status, PFY99

Hospital Type	Amount	Percent
Total Teaching Hospitals	302.9	78.6
Boston Medical Center	150.1	39.0
Cambridge Health Alliance	69.0	17.9
Other Teaching	83.7	21.7
Community Hospitals	82.3	21.4
Total	385.2	100.0

Source: Division of Health Care Finance and Policy Uncompensated Care Reimbursement Data.

Demonstration Projects

Chapter 47 authorized the Division to allocate up to \$10 million of Pool funds per fiscal year for demonstration projects designed to demonstrate alternative approaches to improve health care and reduce costs for uninsured and underinsured individuals. Chapter 47 also designated specific funds for three programs: the Ecu-Health Care project, the Hampshire Health Access project, and the Massachusetts Fishermen's Partnership, Inc. The Division has also selected and funded additional demonstrations via competitive procurements.

Ecu-Health Care, Inc. and Hampshire Health Access

The Division provides \$40,000 annually in Pool funds to the Ecu-Health Care project in North Adams and to the Hampshire Health Access project in Northampton. These programs help link local residents to affordable and accessible health care by assessing their eligibility for state programs such as MassHealth and the Children's Medical Security Plan (CMSP). If applicants are not eligible for a state program, they are referred to local physicians who have agreed to treat patients at a reduced or no charge.

The Massachusetts Fishermen's Partnership, Inc.

The Fishing Partnership Health Plan (FPHP) contracts with Tufts Health Plan and offers fishermen and their families a comprehensive benefit package including access to the Tufts network of providers, mental health services, and pharmacy coverage. Federal and state dollars subsidize the premiums of most plan members. All fishermen, regardless of health status or current insurance coverage, may enroll in the plan. Over 1,200 members of the Massachusetts fishing community are currently covered. The FPHP is a freestanding trust fund that operates separately from the two primary sponsoring organizations: Caritas Christi Health Care System and the Massachusetts Fishermen's Partnership, Inc. It is funded by the U.S. Department of Commerce and \$2 million of Pool funds, and bears all financial risk for the program.

Health Access Projects—Model B Programs

There were two types of Health Care Access projects: "Model A" and "Model B." Model A, which is funded by the Department of Public Health and the Division of Medical Assistance, supports outreach for MassHealth and CMSP in targeted communities. Model B, which was funded by the Pool and is now complete, provided direct services, health education, and referrals to people who did not qualify for MassHealth or CMSP. Nineteen Model B Health Care Access projects were funded from February 1998 through June 1999 with \$180,000 and \$90,000 of Pool funds in the respective fiscal years; all but one was paired with Model A funding.

Congestive Heart Failure

Congestive heart failure (CHF) adversely affects the quality of life of many uninsured individuals and incurs high per-person costs to the Pool. However, many of the associated hospitalizations (and therefore, costs) are preventable with appropriate ambulatory care. The Division began funding five CHF demonstration projects between May and October of 1998, and is continuing to fund four programs. To date, the Division has awarded about \$2 million to fund these demonstrations, and about 200 patients have been enrolled so far. The current program sites are Baystate Medical Center, Boston Medical Center, Brigham and Women's Hospital, and Cambridge Health Alliance. The goals of these programs are to reduce CHF-related hospitalizations, reduce the need for frequent urgent care visits, and improve patient care. The

programs focus on active case management of patients, including weight monitoring, counseling in nutrition and diet, and providing a reliable source of medications.

Demonstrations for Improving Care and Reducing Costs for Uninsured Individuals

In the Fall of 1999, the Division began funding seven programs developed to achieve at least one of three related goals: reduce preventable hospitalizations by providing primary care for patients with ambulatory care sensitive conditions; improve coordination of care for patients with multiple or chronic conditions; and provide services in a more efficient or appropriate manner. The programs are also required to reduce the financial liability of the Pool by at least the amount expended on the programs. The program sites are Boston Health Care for the Homeless Program, Boston Public Health Commission, Falmouth Free Clinic, Family Health Center, Great Brook Valley Community Health Center, Lynn Community Health Center, and South Cove Community Health Center. The programs employ strategies and protocols tailored to the unique characteristics of the uninsured. Program activities include efforts to modify patients' behaviors so they can better manage their diseases, provision of pharmaceuticals, and coordinating care with necessary hospital services.

Section 4: Operational Issues and Stakeholder Perceptions

In addition to conducting empirical analyses using available data, an independent consultant interviewed key stakeholders to learn more about their perceptions of the impact of health reform on the Pool. In this section of the report, we provide results related to these interviews.

Data System

Electronic Application

Key stakeholders identified strengths and weaknesses of the electronic application data system. One strength is that the data system will allow policymakers to follow the history of individuals who cycle in and out of insurance coverage. In addition, the eligibility determination process should be more accurate and consistent. However, some providers believed that the implementation of the electronic application will be burdensome. They worry that the information to be gathered in the application will not be specific enough to actually determine eligibility—for free care or other state health benefit programs—which limits its utility. Providers are concerned that they will have “to do some second-guessing around eligibility for different state programs,” and this may affect their accuracy in determining eligibility for the Pool. Interviewees reported that although there were some delays in the development of the software, the application is currently being used by providers.

Claims Data

Like the electronic eligibility application, most stakeholders are in favor, in theory, of the idea that claims for Pool expenditures should be gathered and analyzed in order to improve Pool management. However, providers suggested that the method DHCFP has proposed for gathering these data has some implementation challenges.

The main provider concern has to do with the data requirements the Division intends to implement. Currently, when hospitals bill the Pool for uncompensated care, they do so after the fact, as a way to write off uncompensated care. As a result, many providers do not save specific information about a case that has been covered by the Pool, because that case has already been “written off”. Thus, many providers do not maintain the level of detail about a case that will allow them to complete a claim form. Providers reported that DHCFP is asking them to complete parts of the UB92 that they do not usually complete even for fully insured cases. Providers emphasized that they have to modify existing systems in order to provide the information requested. As one informant suggested: “This will be a monster to tie together.” The Division has worked with providers to address their concerns and clarify the requirements.

Eligibility for Free Care

According to individuals interviewed for this report, before the Division standardized the eligibility rules and process for free care, each provider had its own credit and collection policy containing its guidelines for free care, and there was no formal oversight of the implementation of these policies. Division staff members have tried to work closely with providers to institute the new application procedures and eligibility guidelines.

One barrier to using the Pool reported by key informants is the “holdover perception” among some front-line workers at hospitals that the Pool is difficult to use and a poor payer. Apparently, some hospital workers do not attempt to ascertain patients’ eligibility for free care because they do not understand the changes that have been implemented to improve management and operation of the Pool. Key informants believe that these misperceptions reflect the difficulty in translating policy changes into “action at the front door” of the provider.

In addition to these eligibility changes, stakeholders report an increase in partial free care since Pool management became the responsibility of DHCFP. Previously, few providers used this option, partially because they did not understand it. In regulations promulgated October 1, 1998, DHCFP clarified the definition of partial free care, and subsequently interviewees perceived that partial free care has increased.

The Uncompensated Care Pool and “Public Charge”

Immigrants may be concerned that enrolling in a publicly funded health care program would cause the US Immigration and Naturalization Service (INS) to consider them a “public charge”—a burden to the public. Public charge determinations can affect one’s ability to become a citizen, to obtain or retain a green card, and to return from travel outside the U.S. In May 1999, the U.S. Government issued new public charge guidelines that outlined when receiving public benefits may result in an immigrant being considered a public charge. In Massachusetts, the use of MassHealth, the Children’s Medical Security Plan, Healthy Start, free care, or other health care benefits will not make a person a public charge.¹⁵ However, according to some individuals interviewed for this report, immigrants worry that using the Pool will make them a public charge. Some front-line hospital workers do not dispute this belief: “The word on the street is to be very careful about receiving services.” The Division has tried to clarify that information on free care applications was never and is not currently subject to review by the INS. Individuals interviewed for this report suggested that some institutions try to work closely with immigrant groups to inform them that it is appropriate to use the Pool. These stakeholders believe it is a constant “mop up operation” and suggest that providers must be particularly aggressive to reach out to immigrant groups and overcome this message.

Appeals

Interviewees revealed that the Division received 17 complaints in 1998. In late 1999, in part because the appeals process became more widely disclosed, the number of appeals increased to 85. Staff suggested that the appeals typically involve eligibility decisions: hospitals were denying coverage inappropriately or not accessing the partial free care option. As hospitals have become more familiar with the standard application process, the number of appeals has declined. Respondents report that there has been a range of individuals who have filed appeals. Stakeholders expressed the belief that the appeals have been “more about the hospitals learning the regulations than anything else.” Most hospitals have never had an appeal filed. Respondents believe that there are few unfounded appeals. For example, interviewees reported that a few (less than five) have included bills from private physicians, which the Pool is not authorized to pay.

¹⁵ Additional information about immigration status appears in Wolfsfeld, Lynn. *Access to Health Care in Massachusetts: A Catalogue of Health Care Programs for Uninsured and Underinsured Individuals*. Division of Health Care Finance and Policy, May, 2000.

Five people appealed because they believed they were eligible for free care but were denied. Upon appeal, they were determined ineligible. Sometimes hospital employees have required excessive documentation (e.g., income tax forms) to verify income. The regulations specify the appropriate and preferred documentation to verify income and residency.¹⁶

Surcharge

Some payers resisted the idea of a surcharge in the context of the Uncompensated Care Pool. They argued that paying hospitals for free care represents reimbursing care in the “last possible service delivery point in the most expensive setting.” In addition, they worried that during the transition to the surcharge, insurers and HMOs might end up double paying for hospital discharges. Moreover, the whole idea of a surcharge makes some payers nervous, especially because the percentage charged has not been accurate. Payers are concerned that even though the Division is statutorily obligated and has pledged to return any excess revenue, the Legislature may change the law and appropriate the excess revenue to another purpose.

Interviewees reported that it has been a challenge to determine the correct percentage for use in the surcharge. The surcharge was originally set at 5.06%. In October 1999, the Division reduced the surcharge to 3.0 percent because, after repaying \$56 million in start-up loans, the state was collecting too much revenue. Respondents said that currently there is an overage of \$28 million associated with the surcharge, which will be adjusted down so that the maximum revenue collected will equal the required amount. This adjustment will take place gradually over a two-year period.

Interviewees reported that in order to implement the surcharge, the Massachusetts Hospital Association and DHCFP compiled names and addresses of payers and wrote to all, asking them to register with the state. Respondents believe the payers have been extremely cooperative about registering and participating in this system. Hospitals are responsible for notifying unregistered payers about the surcharge and must report these to DHCFP. About 900 payers have registered with DHCFP.

Interviewees believe that collections from insurers are going well. Most insurers are “on board” and participated in workgroups leading up to the policy implementation. Occasionally DHCFP has to call insurers to follow up on an error, but policymakers believe these mistakes are generally honest errors rather than attempts to game the system. DHCFP also maintains a hotline for questions about the surcharge.

According to people interviewed for this report, DHCFP is not planning to conduct an audit of the surcharge because it would be difficult and expensive, but it may conduct audits in the future. Instead, DHCFP is verifying surcharge payments by comparing surcharge payment records to hospital records.

¹⁶ Commonwealth of Massachusetts. *Criteria For Determining Eligibility For Free Care At Acute Care Hospitals and Freestanding Community Health Centers, 114.6 CMR 10.02*. Boston: Division of Health Care Finance and Policy, 1998.

Settlements and Shortfalls

Another administrative change to the Pool that resulted from health reform was the transfer of responsibility to DHCFP for final settlements of Pool disbursements to providers. At the time this responsibility was transferred, in 1997, the settlement was being calculated on PFY92. DHCFP has made a concerted effort to improve the timeliness of the settlement process, and at the time of the interviews, in Spring 2000, was close to completing final settlements for PFY97 and PFY98. DHCFP is also working on interim settlements for PFY99. The data being used for the interim settlements have improved in quality, and therefore the interim settlements are closer to what hospitals can expect in final settlements.

The free care costs for hospitals are calculated based on a 12-month rolling average; the 12-month period is based on 3 to 15 months ago, however, not on the past 12-month period. There is some concern that the free care costs initially estimated by the hospitals are too high; therefore, DHCFP pays some of the hospitals a proportion of their costs at first, with the remainder to be determined upon settlement. This varies from hospital to hospital, however.

Demonstration Projects

Another change implemented as part of health reform was the funding of demonstration projects to test new models of providing health services to individuals who receive health care through the Pool (see Section 3). A number of demonstration models are currently being tested. For example, the demonstrations for congestive heart failure (CHF) are now in their third year. At four hospitals in the state, health advocates are reaching out into the community to engage uninsured individuals with CHF into the health care system.

Although all of the CHF demonstration sites use a nurse case-manager to work with patients, each program is slightly different. For example, one program uses a nurse practitioner who conducts home visits. At this site, program staff members believe they have been able to stabilize patients through the program. The typical patient in this CHF program is unemployable due to some physical limitation. He or she has no work history and thus may not be eligible for Medicare; or, the individual earns enough income to be just over the MassHealth means tested eligibility criteria. Often patients do not speak English; some individuals are waiting for heart transplants. Respondents suggest that one strength of the program is the flexibility it gives providers “to tack on the extras that make the medical intervention actually be implemented.” The primary and community-based care perspectives are also key, because connections can be made with patients in their own communities. Demonstration staff members recommend that DHCFP commit to a longer-term relationship with projects from the very beginning. This project started with a six-month commitment, and managers found it difficult to hire quality staff for such a short time period.

Hospital Free Care Networks

Both Boston Medical Center (BMC) and Cambridge Health Alliance operate “loosely managed” care programs for some of their patients who access health care services through the Pool. Each hospital administers its own program and receives no extra payment from the Division for the

program; charges for services are submitted to the Division and treated like all other uncompensated care charges. Each patient is given an identification card, which resembles an insurance card. Cambridge's program, Net A, had about 7000 enrollees in 1998 and about 18,000 enrollees by Spring 2000.¹⁷ BMC has enrolled about 62,000 individuals into its network, "CareNet" (formerly BMC HealthNet). Interviewees suggest individuals who enroll in these programs include those who do not want to enroll in MassHealth. Respondents believe that undocumented immigrants who are afraid of government may be among those who enroll. The uninsured who enroll in these programs also include people with mental health or substance abuse problems, people who are homeless, and people with linguistic barriers.

The Uncompensated Care Pool and the Next Several Years

Providers expressed concern about whether the funds available from the Pool will continue to cover their uncompensated care costs over the next several years. In fact, the Division estimates that a shortfall will re-emerge in PFY00. In the state fiscal years 2000 and 2001, the legislature set aside \$77 million and \$44 million, respectively, to be transferred from the Pool to the state's Children's and Seniors' Health Care Assistance Fund, which funds various MassHealth programs, including the Insurance Partnership.¹⁸ According to key informants, provider uncompensated care costs were covered in PFY99 only because the legislature reduced the scheduled transfer of funds to \$47 million. This reduction made additional funds available for the last three months of PFY99 and for the first 9 months of PFY00. Reducing the scheduled transfer was possible because the Children's and Seniors' Health Care Assistance Fund did not have the anticipated expenditures and the Pool needed additional dollars to cover provider uncompensated care costs in PFY99. While the Pool is projected to have a surplus of \$6 million after the PFY99 final settlement, hospitals worry that the Pool will have a shortfall in 2000.

Cost Pressures

Providers interviewed for this report suggested that they are currently struggling financially. Managed care, the changes implemented as a result of the Balanced Budget Act (BBA), lower Disproportionate Share Hospital (DSH) payments, and static MassHealth rates have all affected provider revenue streams. Hospitals are under additional cost pressure due to the tight labor market in Massachusetts and rising pharmacy costs. Safety net providers believe they are under special pressures because of the populations they serve. Providers suggest that the state play an active role in stabilizing the current market, and that the state could be more visionary in designing solutions to these problems.

¹⁷ Cambridge Health Alliance's Medicaid plan is Network Health; Boston Medical Center's Medicaid Plan is Boston HealthNet.

¹⁸ The Insurance Partnership provides small businesses with partial subsidies of insurance for low-income employees and their families. It can work in conjunction with the MassHealth Family Assistance Program, which offers premium assistance to those who meet the eligibility criteria. See Wolfsfeld, Lynn. *Access to Health Care in Massachusetts: A Catalogue of Health Care Programs for Uninsured and Underinsured Individuals*. Division of Health Care Finance and Policy, May, 2000.

According to some respondents, there are times when different constituencies “take a run on the Pool” to ask for relief and there are legislative and political pushes for Pool reform from time to time. For example, community hospitals are arguing that they are in a severe financial state, and have made a plea for relief from the Pool. Providers are under pressure to maximize revenue and therefore come up with “inventive ways to use the Pool.” Some suggested that it is more important than ever for providers to maximize Pool revenue, particularly in the context of reforms initiated by the BBA.

Overall, however, providers suggested they have been satisfied with the relief they have experienced from changes to the Pool implemented in health reform. There are still some administrative issues with how the Pool is operated but these are “minor in comparison to the relief” obtained. There was not a shortfall in the Pool in PFY98 or PFY99. The changes brought on by health reform have helped enroll people in MassHealth and have helped the two largest providers of uncompensated care to move patients into their free care networks. The system has become more predictable and, relatively speaking, things are “going swimmingly.” Some stakeholders did express concern, however, about the future of the Massachusetts health reform demonstration. In particular, the federal waiver will expire on June 30, 2002, and it is unclear what will happen after that: “People are not thinking out that far: what will happen when the \$70 million [in federal revenues] runs out?” For now, interviewees said there may be “widespread reluctance” to re-open the issue of reforming the Uncompensated Care Pool, given the success of health reform to date and the other issues affecting health care providers in the current market.

Continuity of Coverage

Another issue mentioned by several stakeholders is the apparent cycling of people into and out of various forms of health insurance. This issue has become more important as MassHealth conducts its required eligibility re-determinations. When individuals do not complete the re-determination Medical Benefit Request (MBR), or are determined no longer eligible for MassHealth, they “come back to us [the safety net providers] for care.” In fact, interviewees said the Division of Medical Assistance has had only a 70 percent response rate for the re-determinations thus far. If many of the non-respondents who are disenrolled from MassHealth seek care, the Pool will likely pick up the costs until they re-enroll in MassHealth. Many providers have not observed a drop in the number of people without insurance who present for health services and thus assume that people circulate between MassHealth coverage and the Pool.

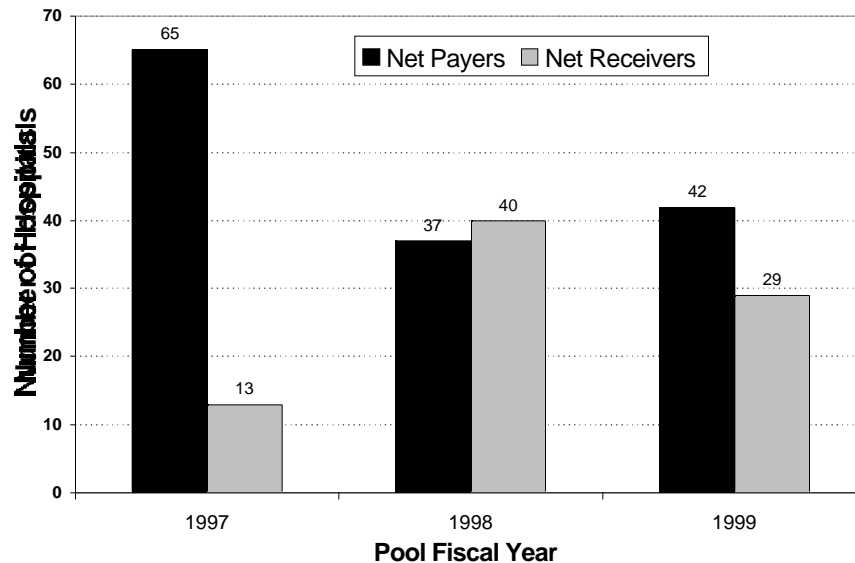
Although outreach efforts have contributed to reduced numbers of uninsured, many people still do not have health insurance coverage in Massachusetts. These individuals are likely to include people who do not fit into MassHealth’s eligibility categories, such as many working uninsured adults. In addition, many parents whose children became eligible through the MassHealth expansions are not themselves covered by MassHealth. There are also some people who are underinsured who still need additional coverage. All in all, however, most stakeholders reported that health reform, including changes in eligibility for the Pool, have “improved the health care coverage landscape in Massachusetts.”

Section 5: Current Status of the Uncompensated Care Pool and Issues for the Future

Trends in Uncompensated Care, 1997-1999

In PFY97, thirteen hospitals were net receivers of Pool funds. The addition of \$85 million annually for uncompensated care, the \$100 million surcharge, and the decreased amounts of uncompensated care requested by providers helped to increase the number of net receivers of Pool funds (see Figure 7). In PFY98, forty hospitals were net receivers of Pool funds; in PFY99, twenty-nine hospitals were net receivers. These changes also created a surplus of Pool dollars in PFY98 and PFY99, ending a series of annual shortfalls that began in PFY89 (see Table 6).

Figure 7: Number of Hospitals Receiving Uncompensated Care Funds by Net Payment Status, PFY97-PFY99



Source: DHCFCP Uncompensated Care Reimbursement Data.

During PFY98, payments from the Pool started to decline at the same time MassHealth enrollment began a steady increase. From PFY97 to PFY99, allowable annual uncompensated care costs to hospitals decreased by 13.6 percent (see Table 6). Although total expenditures from the Pool declined recently, expenditures have increased at Boston Medical Center and Cambridge Health Alliance. These institutions are the state's two largest providers of uncompensated care. Their recent Pool reimbursement levels largely drive the reimbursement levels for the Boston metropolitan region, which have barely declined since PFY97. Allowable uncompensated care costs have declined significantly in all of the regions outside of Boston.

**Table 6: Allowable Uncompensated Care Costs
by Selected Hospitals and Region, Pool Fiscal Years 1997 - 1999**

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Source: Division of Health Care Finance and Policy Uncompensated Care Reimbursement Data.

Next Steps and Recommendations

A number of changes to the Uncompensated Care Pool have been implemented as a result of health reform, including: a standardized eligibility process; the development of a new data system to track eligibility and claims for Pool sponsored services; a surcharge on payers; a clarified appeals process; and the development of demonstration models to test more effective ways to provide uncompensated care. These changes to the Pool have been well received by key stakeholders across Massachusetts. Partially as a result of these changes, the Pool did not experience shortfalls in PFY98 or PFY99; demand on the Pool decreased and there has been an increase in the number of hospitals that are net receivers from the Pool. As described earlier in this report, much has been accomplished through health reform, and all those contacted in the process of completing this assessment are unanimous in their desire to see these gains sustained over the long term.

Recommendations for next steps thus focus on how to build upon the gains made over the last two years. The analysis presented here suggests that future efforts should focus on three main issues:

- Continued investment in data and the ability to link these data among state agencies;
- Continued efforts to improve overall management of the Pool; and
- Sustaining the financing to support the continuation of health reform.

Our analysis of health reform has revealed that many individuals who use the Pool, MassHealth, and other publicly sponsored sources of health care coverage experience changes in their eligibility for these sources of coverage, and sometimes for private sources of coverage. Consequently, these individuals often switch between having a source of health care coverage and being uninsured. This “churning” within the population was greater than expected by some observers. For the first time ever, DHCFP is collecting information about the individuals who use the Pool and soon will collect their utilization of Pool-funded services. This information will be invaluable in understanding more about the characteristics of individuals who rely on the Pool and the services for which the Pool pays. Results from several Pool-funded demonstration programs will help identify ways to deliver services that are efficient and effective in producing improved health outcomes. Additional information about long-term eligibility histories of public beneficiaries is also available from the other state agencies that sponsor public coverage programs, including DMA, the Department of Public Health, and the Division of Transitional Assistance. It is possible to link these different state databases and match individual histories. With such longitudinal data it may be possible to develop comprehensive eligibility strategies to address the churning issue.

DHCFP has made significant progress in improving management of the Pool during health reform. Settlements are being completed in a more timely fashion, regulations have been clarified, and information about Pool operation is more easily available for both consumers and providers. These management and operational changes, combined with the availability of data as described above, should remain a high priority for the Division. Improved efficiency in the operation of the Pool will lead to more opportunity for creative thinking about how Pool dollars can be used for maximum benefit and increased clarity with respect to how the Pool fits into the continuum of publicly sponsored programs that provide health care coverage to Massachusetts residents.

Finally, stakeholders wonder what policy initiatives will follow health reform. Given the success of health reform, it seems natural for individuals involved in the system to look to the future with concerns about how the gains made under health reform can be sustained. Of particular concern among Pool respondents is the role of the Insurance Partnership program (IP), which is funded through the Children's and Seniors' Health Care Assistance Fund, and for which expenditures are anticipated to increase. A shortfall to the 1999 Uncompensated Care Pool was prevented by the Pool's not transferring, as scheduled, dollars to the Fund for the IP and other programs. The Division will be collecting data from the demonstration programs funded, from free care applications, and from the unique claims database, in order to better understand the use of the Pool and inform future Pool policies.

Appendix I: List of Interviewees

Judith Allonby, Division of Health Care Finance and Policy
Frances Anthes, Family Health
Ron Villanueva-Autry, Department of Public Health
Tom Barker, Massachusetts Hospital Association
Christine Ballas, Division of Health Care Finance and Policy
Mary Byrnes, Division of Health Care Finance and Policy
Pat Canney, Division of Medical Assistance
Bob Cooper, Cambridge Health Alliance
Charlene DeLoach, Joint Committee on Health Care, Massachusetts Legislature
Pat Edraos, Massachusetts League of Community Health Centers
Barbara Farrell, Baystate Health Systems
Robin Frost, Massachusetts Coalition for the Homeless
Charles Joffe-Halpern, Ecu-Health Care, Inc.
Marcia Hams, Health Care for All
Jim Hooley, Neighborhood Health Plan
Sarah Kerr Iselin, Massachusetts Hospital Association
Joe Kirkpatrick, Massachusetts Hospital Association
Katharine London, Division of Health Care Finance and Policy
Todd Maio, Department of Transitional Assistance
Paul Matthews, Joint Committee on Health Care, Massachusetts Legislature
Tammy O'Donnell, Neighborhood Health Plan
Scott Penn, Outer Cape Health Services
Mark Reynolds, Division of Medical Assistance
Ann Scannell, Division of Medical Assistance
Tom Traylor, Boston Medical Center
Geoff Wilkerson, Massachusetts Senior Action Council
Kate Willrich, Division of Medical Assistance

Appendix II: Methodological Notes to the Data Analyses

Uniform Hospital Discharge Data Set

We used the hospital discharge data from the state's Uniform Hospital Discharge Data Set (UHDDS), compiled by the Division, to describe the inpatient services received by uninsured individuals. The uninsured were defined as those inpatients with principal expected source of payment of "Free care" or "Self-pay." Discharges for uninsured individuals generally have a payer type of either "Free care" or "Self-pay" in the hospital's data system. "Free care" is used when a free care application is completed for the individual; "Self-pay" is used for individuals for whom the hospital will generate a bill, such as individuals who pay for services themselves. Our understanding is that the records for many individuals with payer type "Self-pay" eventually are converted to "Free care" after hospital staff obtain additional information about patients. The "Self-pay" payer type, however, is not always reconciled if the hospital discovers that another payer exists or if a free care application is eventually processed. In addition, some hospitals do not use the "Free care" code and simply use "Self-pay" to record discharges for uninsured individuals.

Snapshots of the Uninsured

For the description of the uninsured in Section 3, we excluded nonresidents, individuals over 64, and individuals under 19. We combined data for PFY97, PFY98, and the first half of PFY99. We then applied cost-to-charge ratios developed by the Division to convert charges to costs for each discharge. Finally, we summed costs by patient to take into account multiple discharges during the timeframes of the analyses. The clinical profile of the uninsured focused on those 19-64 years old with nonbirth-related primary diagnoses.

Trends in Discharges

For the trend analyses, we compared discharges during PFY97, the year before health care reform, and PFY99, the most current full year. We excluded discharges for nonresidents and for individuals over 64. The trends presented represent discharges, not individuals.

Surveys of Health Insurance

At the time of this writing, only preliminary results from the Division's 2000 Survey of Health Insurance were available. We used estimates from this survey in our presentation of trends. We used demographic data from the Division's 1998 Survey of Health Insurance to describe the uninsured population in Massachusetts. This survey yielded two separate estimates of the number of uninsured: one estimate was derived from telephone responses; a second estimate was derived from a combination of in-person and telephone responses. Although the samples were selected by different methods, each yielded a statewide estimate of the number of uninsured. Details about the surveys can be obtained by contacting the Division.